DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **03-020**

2. STATE: Washington

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2003

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:
a. FFY 2003 $2,106,877
b. FFY 2004 $8,427,506

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-D, pages 1, 2, 5, 6, and 19

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-D, pages 1, 2, 5, 6, and 19

10. SUBJECT OF AMENDMENT:

Nursing Facility Rates

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Exempt

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
DENNIS BRADDOCK

14. TITLE:
Secretary

15. DATE SUBMITTED:

16. RETURN TO:
Department of Social and Health Services
Medical Assistance Administration
925 Plum St SE MS: 45533
Olympia, WA 98504-5533

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: JAN - 4 2005

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL - 1 2003

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Carmen Keller

22. TITLE: DCD

23. REMARKS:

FORM HCFA-179 (07-92)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Washington

NURSING FACILITIES AND SWING BED HOSPITALS

Effective July 1, 2003

Section I. Introduction:

This State Plan Amendment (SPA) to Attachment 4.19-D, Part I, describes the overall payment methodology for nursing facility services provided to Medicaid recipients: (1) by privately-operated nursing facilities, both non-profit and for-profit; (2) by nursing facilities serving veterans of military service operated by the State of Washington Department of Veterans Affairs; and (3) by nursing facilities operated by public hospital districts in the state. Both privately-operated and veterans' nursing facilities share the same methodology. Facilities operated by public hospital districts share the methodology described below also, except for proportionate share payments described in Section XVII below, which apply only to them.

This SPA is submitted by the single state agency for Medicaid, the State of Washington Department of Social and Health Services ("department" below).

Excluded here is the payment rate methodology for nursing facilities operated by the department's Division of Developmental Disabilities, which is described in Attachment 4.19-D, Part II.

Chapter 388-96 of the Washington Administrative Code (WAC), chapter 74.46 of the Revised Code of Washington (RCW), and any other state or federal laws or regulations, codified or uncodified, as may be applicable, are incorporated by reference in Attachment 4.19-D, Part I, as if fully set forth.

The methods and standards used to set payment rates are specified in Part I in a comprehensive manner only. For a more detailed account of the methodology for setting nursing facility payment rates for the three indicated classes of facilities, consult chapter 388-96 WAC and 74.46 RCW, as amended for July 1, 2001, and July 1, 2002, rate setting. Except as otherwise specifically provided in Attachment 4.19-D, Part I, in case

of conflict between the detailed provisions of these chapters and the comprehensive narrative description set forth in Attachment 4.19-D, Part I, the regulatory and statutory provisions shall prevail.

The methods and standards employed by the department to set rates comply with 42 CFR 447, Subpart C, as superseded by federal legislative changes in the Balanced Budget Act of 1997.

Section II. General Provisions:

Medicaid rates for nursing facility care in Washington continue to be facility-specific. Prior to rate setting, nursing facilities' costs and other reported data, such as resident days, are examined, to ensure accuracy and to determine costs allowable for rate setting. Washington continues to be a state utilizing facility-specific cost data, subject to applicable limits, combined with facility-specific and regularly-updated resident case mix data, to set rates.

A facility's Medicaid rate continues to represent a total of seven component rates: (1) direct care, (2) therapy care, (3) support services, (4) operations, (5) variable return, (6) property, and (7) financing allowance.

Medicaid rates are subject to a "budget dial", under which the department is required to reduce rates for all participating nursing facilities statewide by a uniform percentage, after notice and on a prospective basis only, if the statewide average facility total rate, weighted by Medicaid resident days, approaches an overall limit for a particular state fiscal year. For SFY 2004 (July 1, 2003, to June 30, 2004) the budget dial is $144.54 per resident day, and for SFY 2005 (July 1, 2004, to June 30, 2005) it is $147.43 per resident day. The budget dial supersedes all rate setting principles in chapters 74.46 RCW and 388-96 WAC.

The former split budget dial, having one weighted average limit for the non-capital components (direct care, therapy care, support services, operations and variable return) and another weighted average limit for the capital components (property and financing allowance) continued only through June 30, 2001. Effective July 1, 2001, one dial has been re-established for the total rate as indicated.

Direct care, therapy care, support services and operations component rates for July 1,

ordinary nursing facility expenses, costs must be of the nature and magnitude that prudent and cost-conscious management would pay. Effective July 1, 2001, facility costs of televisions in residents' rooms acquired on and after July 1, 2001, will be included in allowable costs.

Cost in excess of limits or in violation of any rate setting or payment principles contained in chapters 74.46 RCW or 388-96 WAC are expressly unallowable. These limits include, but are not limited to, minimum occupancy for rate setting and peer group median costs in affected cost areas and component rates.

Allowable cost limits and principles of rate setting include, in the broad sense, not only those contained in chapters 74.46 RCW and 388-96 WAC, but also those contained an all applicable state and federal laws and regulations, whether codified or uncodified, as may be pertinent to all or part of the July 1, 2001, through June 30, 2004, rate period, as may be interpreted by courts of competent jurisdiction.

The Medicaid payment rate system for the State of Washington does not guarantee that all costs relating to the care of a nursing facility's Medicaid residents and allowable under the payment system rules will be fully covered or reimbursed in any payment period. The primary goal of the system is to pay for nursing care rendered to Medicaid-eligible residents in accordance with state and federal laws, not to reimburse costs, however defined, of a provider.

Section V. Adjustments to Payment Rates for Economic Trends and Conditions:

Effective July 1, 2002, all facilities having their direct care component rates established on case mix principles promulgated in law and regulation, receive a 2.3 percent upward adjustment for economic trends and conditions to their direct care component rates. Any facilities continuing to receive a "hold harmless" direct care component rate as of July 1, 2002, receive no upward adjustment for economic trends and conditions to their direct care component rates; however, the hold harmless provision is terminated effective July 1, 2002, also, so unless this scheduled change to the methodology is eliminated for some facilities, all facilities should receive the 2.3 upward adjustment for economic trends and conditions effective July 1, 2002.

Effective July 1, 2003, all facilities receive a 3.0 percent upward adjustment for economic trends and conditions to their direct care, therapy care, support services, and operations component rates established in accordance with chapter 74.46 RCW.

Section VI. Direct Care Component Rate:

This component rate, which averages approximately 55.5% of each participating facility's total Medicaid rate, corresponds to one resident day of care for in nursing services, including supplies, excluding therapy care services and supplies.

Effective July 1, 2001, direct care component rates are cost-rebased using adjusted direct care costs taken from 1999 cost reports, and applying case mix principles; however, the option to receive a "hold harmless" direct care component rate for qualifying nursing facilities will continue for the July 1, 2001, through June 30, 2002, prospective rate period. The direct care component rates of some facilities will be subject to upward adjustments for economic trends, as specified above, effective July 1, 2001, and July 1, 2002. (See Section V, Adjustments to Rates for Economic Trends and Conditions, above.)

Direct care components rates, as all component rates, are subject to potential prospective reduction under the budget dial described above.

The "hold harmless" direct care provision dates back to October 1, 1998, under which a facility's direct care component rate cannot fall below the facility's "nursing services" component rate in effect on September 30, 1998, subject to adjustment to eliminate therapy services and supplies.

Payments will be distributed directly to the public hospital districts in proportion to the number of Medicaid days of care provided by each district in the preceding calendar year, relative to the total Medicaid days of care provided by the districts statewide during the same year. The supplemental payments will be made once in each federal fiscal year, beginning federal fiscal year 1999, and will terminate July 1, 2005.

Section XVIII. Supplemental Exceptional Care Payments:

Effective July 1, 2001, the department continues to make available two types of exceptional care payments to augment normally-generated payment rates for Medicaid residents.

One type takes the form of increases in the direct care component rate for residents with unmet exceptional care needs, as determined by the department criteria. Direct care payment increases made for these residents shall be offset against a facility's allowable direct care costs for purposes of normal rate setting and settlement.

The other payment shall be a replacement resident-specific therapy care payment rate for qualifying individuals in qualifying nursing facilities. These payments shall be made in place of a facility's normal therapy care component rate for identified residents.

To qualify for an individual therapy care component rate, nursing facility residents must be under age sixty-five, not eligible for Medicare, and be likely to achieve significant progress in their functional status if provided with intensive therapy care services.

All qualifying residents must have a department-approved rehabilitative plan of care and their progress must be monitored periodically by the department. As noted, the therapy care component rate assigned to the facility shall be suspended for residents receiving exceptional therapy care rate payments.